820 Transaction Project
HIPAA Integrated Assessment

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Version 1.2

Document History (Version Control)

Version	Date	Author	Brief Description of Modifications
1.0	11/10/03	Joey Lawhorn	Created
1.1	11/12/03	Joey Lawhorn	Editing from internal review.
1.2	11/17/03	Amy McAllaster	Review of document for distribution

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1 Background

In August 2001, an original Health Insurance Portability and Accountability Act of 1996 (HIPAA) assessment was performed on Medical Care Services (MCS). The assessment identified HIPAA premium payment impacts in two divisions within MCS: the Medi-Cal Managed Care Division (MMCD) and the Payment Systems Division (PSD). In order for the Department of Health Services (DHS) to move forward with its HIPAA compliance efforts, an assessment that focuses on the original findings needed to occur with the intention of identifying to what extent the two Divisions are impacted by the ASC X12 820 Premium Payment Transaction requirements.

Additionally, through the current assessment activities, the discovery was made that the DHS - Financial Management Branch, Accounting Section was also impacted by the need to produce the ASC X12N 820 Transaction, as this Section participates in the health care premium and capitation payment processes.

The objective of *Assessment Phase* of the Transactions and Code Sets (TCS) HIPAA Compliance Life Cycle is to gain a high level understanding of the impacts of the HIPAA mandated ASC X12N 820 Premium Payment Transaction on the DHS Program Business Areas.

During *Phase 2 - Assessment* of the 820 Transaction Project, the project team created three (3) primary assessment documents:

- Business Assessment Document
- Technical Assessment Document
- Legal Assessment Document

The intent of the *Business Assessment Document* is to create a business process inventory documenting the specific impacts of the ASC X12N 820 transaction set on the DHS Program Business Areas. The intent of the *Technical Assessment Document* is to reveal which computer systems and processes used by the DHS Program Business Areas are most likely to be impacted by the ASC X12N 820 transaction. The intent of the *Legal Assessment Document* is to evaluate the regulatory impact of achieving TCS HIPAA compliance. These documents do not define how TCS HIPAA compliance will be achieved in their respective areas; rather, they are intended to guide future efforts in the next phase of the TCS HIPAA Compliance Life Cycle, *Phase 3 - Gap Analysis and Requirements.*

1.1 *Document Purpose*

The Integrated Assessment deliverable is an Executive Summary of the assessment phase. The intent of this document is to summarize the business, legal, and technical assessment findings into one document that cohesively links the independent assessments.

This document will serve to:

- Provide DHS executives and decision makers with a high-level understanding of the current environment that exists today between the current managed care and third party liability operational environments and the requirements for a HIPAA compliant environment.
- Provide all Program Area and Program Business Area supervisors, senior analysts, and information systems technical staff with:

  (1) Enough information to understand the impacts of implementing the ASC X12 820 Transaction, and

  (2) Information regarding the characteristics of the business processes and technical components that will need modifications in order to achieve HIPAA compliance.

1.2 *HIPAA Assessment Process*

The 820 Transaction project team utilized internal assessment methodologies to meet the objectives of the 820 Transaction Assessment project. The approach consisted of a review of preliminary assessment findings performed in August 2001, conducting assessment interviews, performing analysis of findings, and developing the business process information relative to potential HIPAA impacts. Next, the information was organized and reviewed for completeness using the requirements of the HIPAA regulations. Lastly, the results of the analysis were documented in both summary and detailed representations of the findings. The principal findings of the Business, Technical, and Legal Assessments are presented in this document.

2 Summary of Assessment Findings

2.1 *Principle Business Assessment Findings*

1. ***The business assessment identified that the capitation payments for the PACE and the S/HMO programs are made by MMCD on behalf of the Office of Long Term Care (OLTC).***

   Based on this finding, OLTC is excluded from its original covered entity status concerning the 820 Transaction. The capitation payments to the PACE and S/HMO programs were assessed under the MMCD capitation process. Any modifications to MMCD's capitation payment process will include the payments made to the PACE and S/HMO program.

2. ***The business assessment identified the DHS-FMB, Accounting Section as the common route for initiating premium and capitation payments.***

   The business assessment identified that the DHS-FMB, Accounting Section is performing the functions that create the remittance advice for the premium/capitation payment on behalf of MMCD, MDSB, and TPLB. CALSTARS, the State's accounting system, generates the current remittance advice.

3. ***The current Buy-In process supported by TPLB is not impacted by the 820 Transaction*.**

   This determination is supported by page 50338(c) of the TCS Rule Preamble, which states: "The transmission between a State Medicaid Agency and HCFA for the purpose of buy-in is outside of the scope of this requirement. State buy-in, the process by which State Medicaid programs pay only the Medicare premium for certain categories of dually eligible individuals is essentially a Medicaid subsidy, required under Federal law, of Medicare insurance. This transaction is neither an enrollment and disenrollment in a health plan nor a health plan premium transaction."

2.2 *Principle Technical Assessment Findings*

1. ***The Master File capitation worksheet is intended to provide MCOs with the number of Medi-Cal beneficiaries eligible to receive benefits within a particular Aid Code.***

   The Master File is the source of all capitation payment invoices created by MMCD. MMCD utilizes the Master File to calculate, reconcile, and report capitation information to the MCOs. The information contained on these capitation worksheets is specific to the number of Medi-Cal beneficiaries by Aid Code eligible to receive benefits. Aid Codes identify the types of services for which different Medi-Cal beneficiaries are eligible. Each Aid Code is assigned a rate that assists in determining capitation amounts. The Master File contains no formulas for calculating these amounts. This is a manual process. A copy of the capitation worksheet is sent to the MCOs to reconcile their eligibility files. Another copy of the worksheet is sent as an "invoice" to the DHS-FMB, Accounting Section – Medi-Cal Local Assistance Payment Unit to initiate the capitation payment process.

2. ***The premium and capitation payment processing is taking place in the DHS-FMB, Accounting Section. The premium/capitation remittance advice transaction is occurring in CALSTARS as an outcome of this payment process.***

   Currently the DHS-FMB, Accounting Section, Medi-Cal Local Assistance Payment Unit is responsible for the processing of the premium and capitation claim schedules and creating remittance advices in CALSTARS. Once the invoices are received from MMCD, MDSB, and TPLB, the claim schedules are entered into an FMB computer application called CMS64, and uploaded to CALSTARS where a remittance advice is printed. The remittance advice, in addition to other required documentation, is forwarded to the SCO. The SCO then issues a warrant and forwards the warrant with the corresponding remittance advice to the MCO or health plan.

3. ***The assessment identified a potential related systems impact associated with the upload file of claim schedules from the CMS-64 subsystem into CALSTARS.***

   The DHS-FMB, Accounting Section, Medi-Cal Local Assistance Payment Unit (the Unit) is required to report quarterly Medi-Cal expenditures to CMS. In order to collect the necessary information required on Form CMS-64 in an efficient manner, the Unit established the CMS64 subsystem. Instead of entering claims schedules directly into CALSTARS, Unit staff enters the claim schedule information into the CMS64 subsystem to capture the necessary data for reporting purposes. Subsequently, a claims schedule file is extracted from the CMS64 subsystem and uploaded into CALSTARS. If data elements in either CMS64 or CALSTARS are modified in order to comply with the HIPAA 820 Premium Payment transaction implementation specifications, then modifications to the other system may need to occur as well.

2.3 *Principle Legal Assessment Findings*

1. ***To date, there have not been any significant precedents established in case law, or common law, that are pertinent to the standard ASC X12 820 Transaction.***

   As the compliance date for the Transactions Rule passes, and the true extent of the health care industry's compliance deficiencies become evident, we may expect to see an environment ripe for new legal interpretations in this area.[1] HIPAA related judicial precedents would establish a national standard of accepted practice that may encourage individual actions under state law. Under HIPAA, there is no private right of action by an individual.

[1] (2003) U.S Supreme Court opinion 02-215, *Pacificare Health Systems, Inc., et al. v. Book et al*, compelled arbitration of claims for treble damages under the RICO statute, ERISA, and federal and state prompt-pay statutes, for a group of physicians who alleged that Pacificare and United Healthcare unlawfully failed to reimburse them for covered health care services they provided to patients.

2. ***The HIPAA statute provides for civil and criminal penalties for HIPAA violations.***

   For failure to comply with requirements and standards, the Secretary may impose on any person[2] a fine of not more than $100 for each violation, up to a maximum of $25,000 during a calendar year for identical violations of a standard.[3] If the failure to comply is due to reasonable cause and not willful neglect, the Secretary has the discretion to offer technical assistance to an entity, or to reduce or waive penalties.

   A person who knowingly uses or discloses individually identifiable health information in violation of U.S.C. Section 1320d-6 shall be fined not more than $50,000 and imprisoned not more than one (1) year, or both. If the offense was committed under false pretenses, the fine may increase up to $100,000 and/or imprisonment up to five (5) years. If the offense was committed for commercial gain or malicious harm, the maximum penalty increases to $250,000 and/or ten (10) years' imprisonment.[4]

3. ***Data content derived from the 820 Transaction will become a part of a health plan's "designated record set", as defined in the Privacy Rule[5].***

   The designated record set of a covered entity is subject to the access, amendment, and accounting of disclosures provisions of the Privacy Rule. These provisions will need to be evaluated against the requirements at Section 1902(a)(7) of the Social Security Act[6] that limit disclosures of records to beneficiaries be allowed only for "purposes directly connected with the administration of the program".

[2] The term "person" as defined within the Social Security Act, is not limited to a natural person, but may also extend to a corporation, partnership, trust or estate, or agency
[3] 42 U.S.C. Chapter 7, Part C, Section 1320d-5
[4] 42 U.S.C. Chapter 7, Part C, Section 1320d-6
[5] Definition at §164.501 of the Privacy Rule: "*Designated record set means (1) A group of records maintained by or for a covered entity that is (i) the medical records and billing records about individuals maintained by or for a covered health care provider; (ii) the* ***enrollment****, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan…"*
[6] 42 U.S.C. §1396(a)(7). Also, regulations at 42 CFR §431.300-431.307.

3 Gap Analysis Strategy & Next Steps

The findings of the 820 Transaction Project, HIPAA Business, Technical, and Legal Assessments provide a detailed understanding of how the ASC X12 820 Premium Payment Transaction does or does not affect DHS Program Areas including MMCD, MDSB, TPLB, OLTC, and FMB, as well as the affect on the Department of Finance (DOF) as the owner of CALSTARS. The next phase of the HIPAA Life Cycle, known as *Phase 3 - Gap Analysis & Requirements*, determines in detail how large or small the gaps are between the current premium and capitation payment environments and a HIPAA compliant environment for the affected departments and their program areas.

With the completion of *Phase 2 – 820 Transaction Project, HIPAA Integrated Assessment*, DHS Program Areas and the DOF have the understanding of how the ASC X12 820 Transaction may affect them. In *Phase 3 – 820 Transaction Project, Gap Analysis & Requirements* a detailed assessment needs to be performed for all impacted business and technical functions in order to determine the extent of any required effort that will be needed to achieve HIPAA compliance within DHS for the ASC X12 820 Transaction. This analysis identifies and documents the gaps that exist between the current processes and the HIPAA Implementation Specification for the ASC X12 820 Transaction.

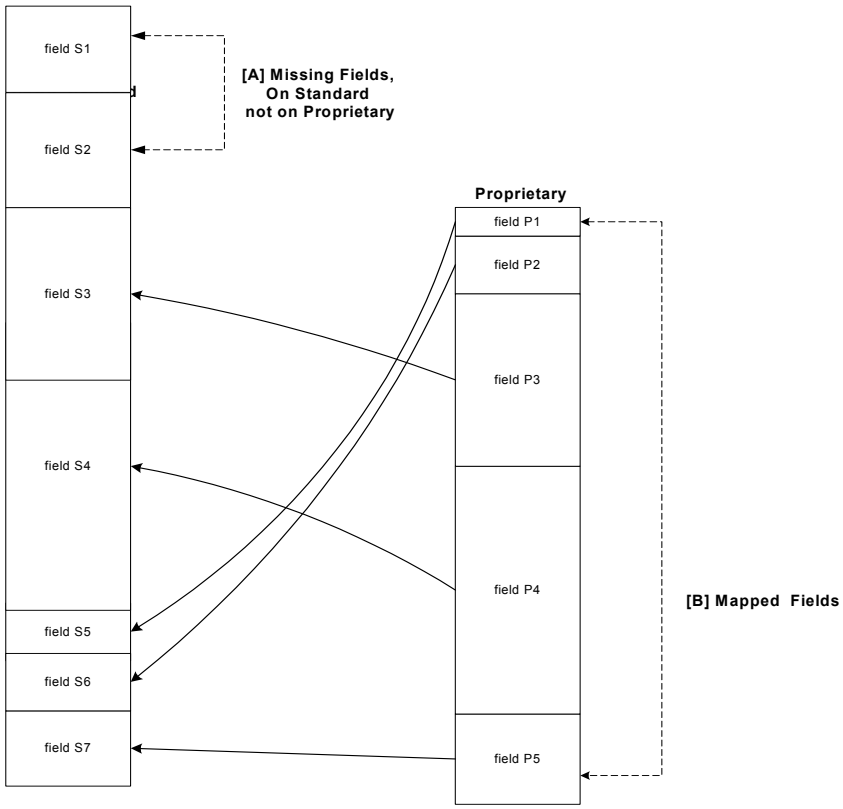
During *Phase 3 – Gap Analysis & Requirements*, for the existing premium and capitation transaction, a field-level transaction mapping to the Standard will be conducted. The transaction mapping identifies which fields match the Standard, and which fields on the Standard cannot be mapped from the existing record (i.e. do not match).

The **Transaction Mapping Example** (Figure 1) is an example of the results of this step. Fields S1 and S2 are on the Standard and not mapped from the proprietary record, Fields S3 - S7 are mapped from the proprietary to the Standard.

For required fields not initially mapped, a series of decisions must be made regarding how to best address them. Issues that are not easily remedied will be tabled and submitted to the Program Business Area Managers for resolution.

Additionally, the HIPAA Business and Technical Assessment results indicated a potential related systems impact between the CMS64 subsystem and CALSTARS. During *Phase 3 - Gap Analysis & Requirements*, it is important that these computer systems and their internal and external processing flows be mapped out in order to understand how data is received and perhaps translated before being input into or received by other computer systems.

Figure 1. Transaction Mapping Example



Upon completion of the *Gap Analysis & Requirements* phase, the 820 Project Team will be positioned to develop solution alternatives, select a series of solutions that best meet the Program Area's goals, and implement the appropriate solutions. Remediation activities can be better identified and planned for after the completion of all Gap Analysis & Requirements activities.

It will be important for the 820 Transaction Project Team to use an integrated approach with the various Program Business Areas in order to achieve compliance. The benefit of integrating the work efforts of all parties involved with the 820 Transaction will be the opportunity to mitigate risks and reduce costs by leveraging technical solutions and interdepartmental process improvements simultaneously.

4 Integrated Assessment Approval

We have reviewed the document "*820 Transaction Project, Payroll Deducted and Other Group Premium Payment for Insurance Products, HIPAA Integrated Assessment*" and hereby approve it as the official DHS position.

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